

APPENDIX A – ADDENDUM #1

BACKGROUND INFORMATION

1. Current Process for Managing Voluntary and Involuntary Psychiatric Beds in the State of New Hampshire

1.1. Emergency Department –

- 1.1.1.** Staff seeking an inpatient psychiatric bed for a patient waiting in the Emergency Department typically make contact with potential treatment sites by telephone and fax to determine if an appropriate bed is available for the patient.
- 1.1.2.** If an appropriate bed is available, staff submit associated referral information to formally request the bed.
- 1.1.3.** Patient specific information is typically transmitted through these same means, although in some instances hospital to treatment site EMRs or SFTP transmissions may be accommodated.
- 1.1.4. Note:** Patients in Emergency Departments may need an inpatient psychiatric bed on an involuntary or voluntary basis.

1.2. Designated Receiving Facility (DRF)

- 1.2.1.** Staff receive patient referrals from Emergency Department staff and manually review the referral information to determine if the patient is an appropriate fit for the facility and applicable bed, if one is indeed available.
- 1.2.2.** The staff then manually, as described above, notifies the requesting Emergency Department whether the Designated Receiving Facility (DRF) will accept or defer the referral.
- 1.2.3.** If accepted, the two sites will complete the transfer of information necessary to fulfill the patient's transfer; this too is largely a manual process, although some sites may have EMR-to-EMR or SFTP transmissions to assist.
- 1.2.4.** If the patient is accepted, the DRF staff will update its inventory of available inpatient psychiatric beds and communicates this information to the New Hampshire Hospital Association, in a separate manual process.
- 1.2.5. Notes:** DRFs may accept patients requiring an inpatient psychiatric bed on an involuntary or voluntary basis. However, most DRF beds are utilized for involuntary admissions, which is a court involved process. DRFs may also receive patient referrals from other DRFs, NHH, and community hospitals.

1.3. New Hampshire Hospital (NHH)

- 1.3.1.** Staff follow much of the same process described in 1.2 above. However, NHH can be named as the designated location for certain patients needing admission on an involuntary basis.
- 1.3.2.** Although NHH is technically a DRF, as New Hampshire's only State-run acute care inpatient psychiatric hospital, it has management and oversight responsibilities associated with all patients awaiting an inpatient psychiatric bed on an involuntary basis.

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- 1.3.3.** In addition to the processes described in 1.2 above, NHH staff manually communicate with multiple Emergency Departments and DRFs, statewide, to manage the flow and transfer of patients.
- 1.3.4.** Bed availability is a consistent challenge. Due to this fact NHH staff manage a waiting patient queue for involuntary admissions (in Excel format). Patients are added to the bottom of the queue as referrals are received. As part of managing the queue, designated NHH staff have the ability to move patients up and down the queue as beds become available. Other factors that may impact a patient's current placement on the queue include:
 - 1.3.4.1.** Whether the patient's acuity improves or worsens while waiting; the progress of receiving required information for admission from the applicable Emergency Department.
 - 1.3.4.2.** A patient's legal status (such as a rescinded conditional discharge from a prior NHH admission).
 - 1.3.4.3.** If there are specific patient characteristics that impact appropriate bed availability (such as a child, a senior, etc.).
- 1.3.5. Note:** NHH has a specialized center, the Anna Philbrick Center, for children needing an inpatient psychiatric bed at NHH on an involuntary or voluntary basis. For this reason, NHH currently manually maintains a separate patient waiting queue for these children that is inclusive of involuntary and voluntary admissions. (The same methods of manually communicating with referring organizations as described in 1.1. applies for such cases).
- 1.4. Community Hospitals (Non-Emergency Department).**
 - 1.4.1.** Some Community Hospitals have inpatient psychiatric beds available/in-use for patients on a voluntary basis.
 - 1.4.2.** These beds are currently not part of any centralized tracking process.
- 1.5. Community Mental Health Center (CMHC)**
 - 1.5.1.** Staff provide a variety of services to psychiatric patients within the community setting, and are a common referral source for patients needing treatment in an inpatient psychiatric bed at a DRF or NHH.
 - 1.5.2.** CMHC staff may assist patients with accessing an Emergency Department to seek an inpatient psychiatric bed on a voluntary, involuntary and rescinded conditional discharge basis. In such cases, the processes described in 1.1 above would largely be followed with the exception of some patient specific information being provided by the CMHC to support an appropriate placement of the patient.
 - 1.5.3.** CMHCs are typically involved with such patient's subsequent discharge from an inpatient psychiatric bed and a similar manual process between NHH (or another DRF) with the applicable CMHC is utilized to support patient

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discharge and return to the community setting.

1.6. New Hampshire Hospital Association (NHHA)

- 1.6.1. NHHA provides an electronic (Excel based) tracking report of the number of available and unavailable inpatient psychiatric beds per facility.
- 1.6.2. The report is updated at least daily with inputs manually received from DRFs and NHH.

1.7. New Hampshire Courts

- 1.7.1. New Hampshire Courts are involved in cases for patients needing an involuntary admission to an inpatient psychiatric bed.
- 1.7.2. The Courts are not directly involved in the patient referral process.
- 1.7.3. However, the Courts receive patient specific information (such as petitions), through a manual process. Information is received from involved treatment site(s) as part of a patient's progression through the involuntary admission process.
- 1.7.4. Orders subsequently issued by the Court may enable an involuntary admission to continue or terminate and may impact patient admission and discharge; orders are manually communicated to the involved treatment site(s).

1.8. Correctional Facilities (State and County Levels)

- 1.8.1. Correctional Facilities at both the state and county levels are involved in cases for patients needing an involuntary admission to an inpatient psychiatric bed if the person (pursuant to a Court order) is held in prison or at a county jail until a bed becomes available at NHH or another DRF.
- 1.8.2. Communication between the applicable correctional facility and NHH or another DRF regarding such patients are manually transmitted.

1.9. Secure Psychiatric Unit (SPU)

- 1.9.1. The SPU is a State-run secure psychiatric unit housed within the NH State Prison for Men, centrally located in Concord.
- 1.9.2. The SPU can refer patients to admission to NHH through a manual process as described in 1.1. above.
- 1.9.3. Similarly, NHH can refer patients to SPU. Acceptance, transfer and discharge of such patients is manually communicated between the two sites, involves the Courts, and involves law enforcement personnel to assist with transfer.

1.10. Guardians and Parents of Children

- 1.10.1. Guardians and parents have the ability to refer their ward or child for admission to NHH or another DRF for an inpatient psychiatric bed.

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- 1.10.2. Typically, such referrals will be initiated by the ward or child's presentation at an Emergency Department, and the processes described in 1.1. are followed.
- 1.10.3. Guardian and parental consent become part of the documentation required for admission and, in some cases, may be required for patient discharge and return to the community, or transfer to another treatment site post admission.

1.11. Health Insurance Payers

- 1.11.1. Health insurance payers may be involved in a patient's ability to be accepted into an appropriate inpatient psychiatric facility for treatment.
- 1.11.2. If prior authorizations are needed by a potential receiving treatment site, such as a DRF, the sending site, such as an Emergency Department, communicates with the applicable health insurer to secure the authorizations.
- 1.11.3. This process may be manual or may be automated through the treatment site's EMR and the payer's applicable information system.
- 1.11.4. For patients being discharged from an inpatient psychiatric bed, the discharging treatment site or supporting community provider, such as a CMHC, may require the payer's prior authorization for services that the patient will be required to receive upon discharge as well as the medications that may need to be filled.
- 1.11.5. Discharges may be delayed if the requirements to support patient stability upon return to the community are not successfully addressed.

1.12. DHHS State Agencies

- 1.12.1. DHHS state agencies involved in the oversight and management of the state mental health system create a daily (Monday through Friday) Wait List report that lists the (de-identified) patients that are in queue for admission to NHH or another DRF.
- 1.12.2. The report is developed in Excel and is emailed to a large group of providers, stakeholders and DHHS staff who have requested this report to support efforts to expedite patient transfer and reduce the Wait List. The report indicates the:
 - 1.12.2.1. Location of the patient.
 - 1.12.2.2. Referral source.
 - 1.12.2.3. Date and time the referral was initiated.
 - 1.12.2.4. Patient age.
 - 1.12.2.5. Primary and secondary insurance payer (if known).
 - 1.12.2.6. Total number of children waiting.
 - 1.12.2.7. Total number of adults waiting by location (inclusive of Emergency Departments, Correctional Facilities, and SPU).

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- 1.12.3.** The report is prepared in two (2) versions -- patients listed by referral source and patients listed by health insurer – to assist CMHCs and health insurance payers with rapid assessment of their current patient volume waiting for an inpatient psychiatric bed.
- 1.12.4.** Patient specific information (patient name, date of birth, health insurance plan and in some cases, member number) is provided to the applicable health insurer for those patients participating in one of the State's two Managed Care Organization (MCOs) and to three private health insurance payers.
- 1.12.5.** The information distributed to the MCOs is provided to the applicable MCO through the State's Medicaid Management Information Systems (MMIS) secure portal. The information distributed to the three private health insurance payers is communicated by telephone to the applicable payer. This reporting is in place to improve collaboration between providers, health insurances, and State agencies to expedite patient transfer and to timely deliver appropriate treatment.

2. Department of Health & Human Services

2.1. The Department of Health & Human Services (DHHS), Division for Behavioral Health (DBH) oversees and coordinates Department of Health and Human Services programs and policies for mental health services and substance use disorder services. DBH oversees and manages the following New Hampshire service systems, which provide services to both children and adults:

- 2.1.1. Bureau of Mental Health Services (BMHS)** - Community based mental health services for adults.
- 2.1.2. Bureau for Children's Behavioral Health (BCBH)** - Children's behavioral health services.
- 2.1.3. Bureau of Drug and Alcohol Services Substance (BDAS)** – drug and alcohol use prevention and disorder treatment and recovery services for adults and children.
- 2.1.4. New Hampshire Hospital (NHH)** – an inpatient psychiatric acute care hospital.
- 2.1.5. Glenclyff Home** – a nursing facility for individuals who are developmentally disabled or have mental illness.

2.2. Other Resources, Providers and Stakeholders

- 2.2.1. Designated Receiving Facilities (DRF) – five (5)** DRF facilities –four (4) which are hospitals (including New Hampshire Hospital) and one (1) which is a residential facility – currently exist to receive and treat patients in need of psychiatric services. Patients admitted to New Hampshire Hospital are usually on an involuntary emergency admission (IEA) basis. Patients admitted to other DRFs may be admitted on a voluntary or involuntary basis.

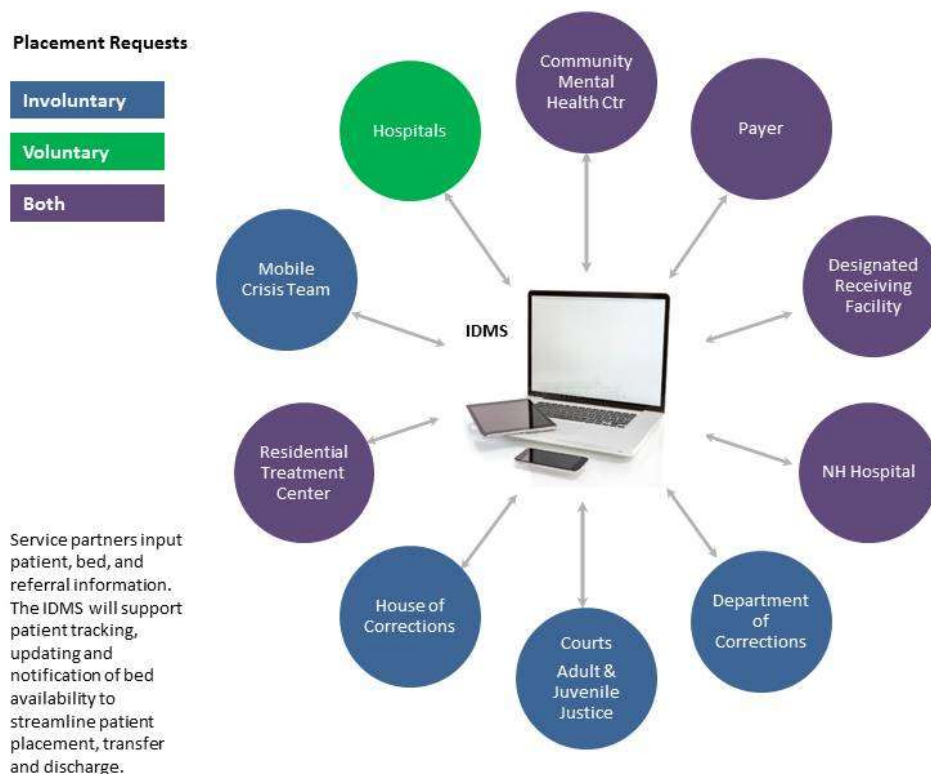
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- 2.2.2. Community Mental Health Centers (CMHCs) – ten (10)** CMHCs are the primary deliverers of community based mental health services for adults and children.
- 2.2.3. Hospital Emergency Departments (ED) – twenty-six (26)** emergency departments receive patients experiencing an emergency need for acute psychiatric treatment.
- 2.2.4. Hospitals – eleven (11)** of the state’s community hospitals have voluntary psychiatric beds.
- 2.2.5. Substance Use Disorder (SUD) Providers** – a network of SUD community based service providers deliver a variety of SUD services at varying levels of care. Residential beds available for patients experiencing an SUD are not currently part of the Waiting List and referral and bed management processes described in Appendix A, Section 1, however these beds and associated provider community and processes are not included in Phase I of the IDMS that is the subject of this RFP but ***may be included in subsequent phases*** not currently authorized or funded for this project. This information is included only to inform vendors of potential expansion opportunities for the IDMS.
- 2.2.6. Community Residential Providers** – there are a variety of private community residential providers participating in the State’s adult mental health system, children’s behavioral health system, juvenile justice system, and elderly and adult long term/specialized care providers. These beds and processes are not included in Phase I of the IDMS that is the subject of this RFP but ***may be included in subsequent phases*** not currently authorized or funded for this project. This information is included only to inform vendors of potential expansion opportunities for the IDMS.
- 2.2.7. Health Insurance Payers** – New Hampshire currently has **two (2)** Medicaid Managed Care Organizations, and three **(3) private payers** that join efforts with the State to effectuate prompt treatment and transfer of psychiatric patients. Other insurance payers, including out of state insurance payers, may also be involved in the system.
- 2.2.8. New Hampshire Courts** - Courts hear and rule on petitions for involuntary emergency admissions. Although the Courts have a role in the processes described in Appendix A, Section I, the Courts’ use of the IDMS is not included in Phase I but ***may be included in subsequent phases*** not currently authorized or funded for this project. This information is included to inform vendors of the Court’s current role in the processes the IDMS will address, and for potential expansion opportunities for the IDMS.

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2.3. Project Overview/Justification

- 2.3.1.** *The Department is seeking a Contractor to develop and implement an integrated data management system that provides real time, as described in Appendix H-1 Terms & Definitions, information about the availability of involuntary and voluntary inpatient psychiatric beds in the State of New Hampshire in order to reduce the length of time individuals spend waiting for inpatient services.*
- 2.3.2.** *The Integrated Data Management System (IDMS) will allow for increased communication between service providers to ensure individuals are expeditiously triaged and receive the acute inpatient psychiatric care needed. The illustration below indicates potential users of the IDMS.*



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2.4. Goals and Objectives for the Integrated Data Management System

- 2.4.1.** The Department's preliminary objectives for an integrated data management system that will meaningfully contribute to reducing the number of patients waiting within an emergency department setting for entry to a psychiatric bed include:
- 2.4.1.1.** Review and confirm Phase I requirements and assess steps to be taken to fulfill Phase I requirements, and evaluate future needs and estimated timeframes. A Phase I readiness assessment within the first 30 days of the contract's effective date and a Phase II assessment within the first six months of the contract's effective date will support this objective.
 - 2.4.1.2.** **Developing a highly responsive system to provide real time information sharing.** The Department understands that Phase I system functionality may not be able to be fully operationalized initially, and that some functionality may require incremental implementation. This may result in the initial system information sharing being limited to real time inpatient psychiatric bed inventory, availability, and queue generation, followed by the transfer of additional patient information, such as medication lists, clinical assessment data, etc. to support triage and transfer processes, automated sharing of data with NHH Care Connect, etc. However, the system must be able to receive and transfer baseline patient and bed information to and from participating treatment providers/sites in order to provide real time information about bed availability.
 - 2.4.1.3.** **Develop a highly scalable system capable of achieving right-sized interoperability with treatment sites' EMRs, networked data transfer tools, and shared care plans in Phase II and other future phases of development.**
 - 2.4.1.4.** **Reduce manual processes.** While HB517 requires that the system addresses the availability and tracking of inpatient psychiatric beds, in practicality this is informed by the flow of patients and by the prompt triage of the patient's treatment needs and decisions to transfer patients between sites. The proposed solution must have the ability in Phase I to reduce current manual processes that impact the flow of patients from one treatment site to another. In the future, Phase II functionality will further reduce manual processes by automating the collection of additional patient specific information needed to assess patients, ensure patient and quality of care, the transfer of medication lists, court related documentation, etc. between provider and treatment site EHR/EMR systems.
 - 2.4.1.5.** **Accommodate a variety of authenticated role based users accessing the solution in various settings and with various**

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devices, and through multiple platforms. The solution developed must be able to accommodate potentially hundreds of users who will have varying degrees of input and access privileges into the system, and who will access the web based system through devices ranging from wall-mounted computer stations, laptop/ desktop computers, to smartphones and tablets.

3. Department of Information Technology and Technology Status

The Project will be conducted in cooperation with the New Hampshire Department of Information Technology (DoIT). DoIT coordinates the statewide Information Technology activities.

3.1. Components of the State's Technical Architecture

- 3.1.1. State Network Environment:** The State operates multiple wide-area networks using various technologies including frame relay, fiber, dedicated lines, and wireless, Voice over IP (VOIP) and VPN technologies. Networks have varying levels of integration and connectivity to the statewide core for resource sharing and centralized administration by the Department of Information Technology (DoIT). Direct support is provided for twenty-one partner agencies; other State agencies support their own networks, out-source the support, or use the resources of another agency.
- 3.1.2. Internet Access:** All State agencies are connected to the State's intranet which is being redesigned to function as the statewide core network in addition to facilitating access to e-mail, the Internet, and the State's financial applications. Some agencies additionally have their own Internet service providers.
- 3.1.3.** The State uses **VMWare for Windows** server virtualization and virtual hosts are deployed at two separate State campus sites. VMWare provides a highly scalable and high availability environment for the State's many Agencies. If a virtual host fails, VMWare automatically fails over all of the virtual servers on that host to another host. The EMC Networker product is used to manage backups for this environment utilizing Data Domain as the disk to disk repository.
- 3.1.4.** For the State's **Oracle** enterprise systems, an Oracle/Linux solution (OVM) is used for the virtual environment. Similar to the windows environment, this solution provides a highly scalable and high availability environment and also utilizes the EMC Networker and Data Domain backup solution. Data Domain is also employed to meet the backup requirements within OVM

3.2. Future Systems Environment

- 3.2.1.** Future design and development efforts should conform to the emerging environment as defined by current information technology initiatives, the New Hampshire Statewide Strategic Information Technology Plan, and the State's e-Government Architecture Plan.

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- 3.2.2.** This environment is end user centric, utilizing the Internet and Web whenever possible, promoting electronic transactions, and centralized common services (security, e-payment, content search), where possible.

4. Related Documents Required

- 4.1.** Vendors are NOT required to submit these certificates with their proposal. Vendors may be required to be a registered company in New Hampshire. The certificates will be requested from the selected Vendor prior to Contract approval.

- 4.1.1.** Certificate of Good Standing (Appendix G, Section 4, Certificates) dated after April of the current year and available from the Office of the Secretary of State.

- 4.1.2.** Certificate of Vote (Appendix G, Section 4, Certificates)

- 4.1.3.** Proof of Insurance compliant with Appendix H: *State of New Hampshire Terms and Conditions*.

5. State Project Team

State high-level staffing for the Project will include:

5.1. The Project Sponsor

The Project Sponsor, the Director for Behavioral Health, will be responsible for securing financing and resources, addressing issues brought to his or her attention by the State Project Manager, and assisting the State Project Manager in promoting the Project throughout the State. The Project Sponsor or an appropriate designee will be available to resolve issues on a timely basis.

5.2. State Project Manager

The State Project Manager, the Bureau of Mental Health Services' Community Integration Coordinator, or an appropriate DHHS designee will be will be the primary DHHS contact for the project.

The DHHS Project Manager will interact with the Vendor, DHHS Systems Architect, and Business Stakeholders to address questions, concerns, or issues encountered during the daily performance of the project. He/she will be the non-technical liaison between the project and the executive sponsors